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Smoking in child Family Day Care homes: policies and practice in New South Wales

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Objectives: To provide estimates of the numbers of New South Wales children in Family Day Care who may be exposed to environmental tobacco smoke while attending day care; to describe existing smoking policies; and to analyse these policies with the aim of providing guidelines for smoking policy in Family Day Care.

Setting: All 109 Family Day Care schemes in NSW.

Method: Scheme coordinators were sent a questionnaire regarding the proportion of carers who smoked while caring for children; the nature, enforcement and experience of smoking policies; and barriers to implementation of a no-smoking policy.

Results: A mean of 10% of Family Day Care caregivers were reported to smoke while caring for children (range, 0–60%). An estimated 2045 children were potentially exposed to environmental tobacco smoke in the 86 schemes which provided this information. Thirty-five per cent of schemes had formal no-smoking policies. A range of advantages, disadvantages and perceived practical and legal barriers to implementation of a no-smoking policy in Family Day Care were described. Forty-four per cent of schemes with no-smoking policies reported no implementation problems.

Conclusions: There is considerable potential for exposure of children to environmental tobacco smoke in Family Day Care homes. There is legal support for Family Day Care caregivers not to expose children under their care to environmental tobacco smoke. A formal (and enforced) no-smoking policy should exist in every Family Day Care scheme, and a "top-down" directive is most likely to be successful. The issue of other smokers in the caregiver's household needs to be specifically addressed in any such directive.

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Substantial numbers of reports exist in the medical literature stating that exposure to environmental tobacco smoke by children is associated with an increased incidence of lower respiratory illness,[1-5] the development and persistence of airflow limitation in wheezing children,[6] asthma[7] and diminished pulmonary function.[8,9] A graded increase in respiratory symptoms has been shown among children with none, one and two smoking parents.[10] Continuous parental smoking has been shown to retard functional lung growth in boys who started childhood with low lung function.[11]

Cotinine levels in children admitted to hospital have been found to correlate highly with current parental smoking.[5,12] An American study found that 61% of infants who did not excrete cotinine at age three weeks did excrete it at one year, reflecting an increased exposure to household and, particularly, non-household sources of smoke. The proportion of infants in this study who were exposed to non-household smokers increased from 14% to 36%.[13]

Outside the home, the major potential for exposure to environmental tobacco smoke in infants and young children occurs during child care. This may be an informal arrangement involving relatives and friends or formal child day care, including before and after school programs, pre-school or kindergarten, long day care centres and Family Day Care. In Family Day Care, children are minded in private homes by caregivers (nearly always women) who are often also looking after their own children. In Australia, Family Day Care, rather than institutional services, offers the greatest potential for exposure of children to environmental tobacco smoke because it is not subject to explicit regulations covering smoking in the workplace.

There have been few studies on environmental tobacco smoke exposure in children attending formal child care, and these focus on long day care centres. Etzel et al.[14] studied 139 children attending long day care and found that both the rate of new episodes of otitis media with effusion during the first three years of life, and the duration of these episodes, were associated with serum cotinine concentrations. They estimated that 8% of the cases of otitis media with effusion in this population, and 17.6% of the days children suffered this infection were attributable to exposure to tobacco smoke, but did not specify the source of exposure. A matched case–control study of children aged 3–59 months attending day care found the most important predictors of serious infection which required

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hospitalisation (excluding infections with *Haemophilus influenzae* and *Neisseria meningitidis*) were environmental tobacco smoke and sharing a bedroom.[15] However, they questioned only parents on whether or not they smoked and did not enquire whether day care staff smoked when minding children. Butz and Rosenstein[16] found that a third of children they surveyed were exposed to environmental tobacco smoke at home and/or at day care on a daily basis. They recommended that health care providers enquire about potential sources of environmental tobacco smoke exposure in their patients, particularly children with chronic respiratory disease.

Nelson et al.[17] surveyed 2003 directors of licensed day care centres in the United States to estimate the extent of exposure of children to environmental tobacco smoke, and the extent of compliance with relevant laws and regulations on clean indoor air. They found 55% of centres were smoke-free both indoors and outdoors, and commented on the often unregulated status of family day care, suggesting less likelihood of compliance.

In Australia, Family Day Care is a service offered in private homes by registered caregivers. Family Day Care schemes are networks of caregivers supported by a central coordination unit, which is responsible for recruiting caregivers, organising placements and inspecting homes to ensure that they comply with State regulations and scheme policies. Some schemes are run under the aegis of local councils, others by church groups or private bodies. Family Day Care homes were attended by 60 202 children in 1991,[18] accounting for around 14% of all formal care for children under 12.[19] Smoking policies in Family Day Care, or the lack thereof, are determined by the administrators of individual schemes. This survey was conducted to provide estimates of the numbers of children in Family Day Care in New South Wales who may be exposed to environmental tobacco smoke, to gather data on existing smoking policies and to analyse these policies with the aim of providing guidelines for smoking policy in Family Day Care.

Methods

A questionnaire was sent to the coordinators of all 109 licensed Family Day Care schemes operating in New South Wales. Non-responders were followed up by telephone. Information was sought about the size of each scheme; coordinators' estimates of the proportion of carers who smoked while caring for children; the nature, enforcement and experience of smoking policies; and barriers to implementation of a no-smoking policy. Data were coded and entered in a database. For comparisons of proportions, the Yates corrected χ^2 test statistic was used.

Results

Eighty-eight responses were received from the 109 licensed schemes. Of these, six were found to represent 13 schemes with joint administrations. Thus 88 out of a possible total of 102 responses were received, giving a response rate of 86.3%. The 88 responses represented 3829 Family Day Care homes (mean 43.5 per scheme), attended by 20 208 children. A mean of 5.3 children attended each home.

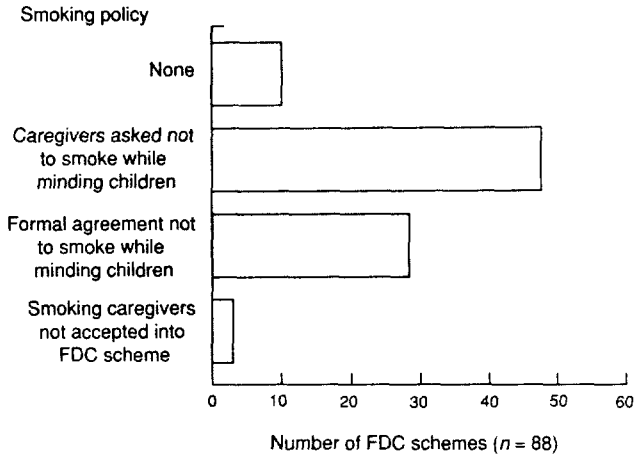
Scheme coordinators estimated that between 0 and 66% of caregivers in their scheme smoked while caring for children (mean, 10%). Two coordinators did not answer this question. The vast majority of coordinators who answered this question believed that their estimate of the proportion of smoking carers was reasonably accurate (78/86, 91%). An estimate of the number of children potentially exposed to environmental tobacco smoke while attending Family Day Care was obtained by multiplying the proportion of smoking caregivers in each scheme by the number of children cared for in that scheme. An estimated 2045 children were potentially exposed in the 86 schemes for which information was available.

Smoking policies

Ten coordinators (11%) reported that their schemes had no policy about smoking. A further 47 (53%) reported that caregivers were asked not to smoke while caring for children, but there was no formal policy on the issue. A formal agreement not to smoke while minding children was required by 28 Family Day Care schemes (32%), while smokers were not accepted as caregivers in a further three (3%) (see the Figure). Of the 31 schemes with formal no-smoking policies, only 13 (42%) required a written agreement from caregivers not to smoke. Sixty-nine coordinators (78%) reported that parents were advised of caregivers' smoking status when placements were arranged. Fifty-six (64%) reported that home inspections routinely included an assessment of whether children were exposed to cigarette smoke. These schemes with routine assessment of exposure represented 27 of the 31 (87%) with formal policies on smoking and 29 of the 57 (51%) that had no formal policy.

Complaints about smoking caregivers

Fifty of the 88 coordinators (57%) had received complaints from parents about caregivers who smoked in the presence of children. Schemes with



Smoking policies in New South Wales Family Day Care (FDC) schemes.

ormal no-smoking policies were slightly less likely to report having received complaints (16/31, 52%) than those without policies (34/57, 60%). This difference was not statistically significant ($\chi^2 = 0.3$, $P = 0.6$). Thirty-three schemes (38%) had a formal procedure for investigating such complaints.

Opinions on a no-smoking policy in Family Day Care (FDC) reported by coordinators ($n = 88$)

Advantages	
Better health of children	65 (74%)
Enhancement of professional image of FDC	22 (25%)
Easier placement of children	18 (21%)
Decreased chances of litigation	17 (19%)
Provision of better role models for children	8 (9%)
Other	12 (14%)
No response	9 (8%)
Disadvantages	
Potential loss of caregivers	33 (38%)
Infringement of caregivers' personal rights	21 (24%)
Difficult to enforce	16 (18%)
Difficult to impose on caregivers' families, visitors	9 (10%)
No disadvantages	6 (7%)
Other	15 (17%)
No response	10 (11%)

Advantages and disadvantages of no-smoking policies

Seventy-nine of the 88 respondents (90%) described advantages of a no-smoking policy (see Box); the remaining nine did not respond to this question. By far the most frequently mentioned advantage was better health of the children, cited by 65 of the 88 respondents (74%). Other frequently mentioned benefits were enhancement of the professional image of the Family Day Care scheme, decreased chances of litigation and provision of better role models for children.

Seventy-two of the 88 respondents (82%) listed disadvantages of a no-smoking policy (see Box). Six respondents felt that there were no disadvantages to such a policy and the remaining ten did not respond to this question. The most commonly mentioned disadvantage was potential loss of caregivers (cited by 33 respondents, 38%). Among the other frequently described disadvantages were infringements of the personal rights of caregivers, difficulties of enforcing such a policy and problems of imposing it on caregivers' family members and visitors.

Implementation of no-smoking policies

When asked if they could think of any practical or legal barriers to implementation of no-smoking policies, 58 of the respondents (66%) described such barriers, 19 (22%) felt there were no barriers, and 11 did not respond. Legal rights of caregivers as self-employed workers within their own homes was the most frequently perceived barrier (cited by 32 coordinators, 36%), followed by the personal rights of caregivers and their families and friends (26, or 30%), and difficulties with policing and enforcement of such a policy (15, or 17%). Coordinators of schemes without formal policies were more likely to report barriers to implementation (41/57, 72%), compared with those with formal policies (17/31, 55%). This difference was not statistically significant ($\chi^2 = 1.9$, $P = 0.2$).

Of the 31 schemes with formal policies, 25 (81%) volunteered details of their experiences in implementing the policy. Of these, 11 (44%) said that there had been no problems. The most frequently mentioned difficulty was that of imposing the policy upon caregivers' spouses, adult children and visitors (described by six coordinators). Four others had had problems policing the policy and two had difficulties with defining the limits of a "no-smoking zone" — did it include the garden or even a nearby park?

Strategies which were employed in implementing no-smoking policies included holding workshops for caregivers which focused on issues such as positive role modelling, health effects of environmental tobacco smoke, possibility of future legal liability, effect of the policy on caregivers' health and flow-on benefits to their families. Other strategies included circulating information from the government's *Quit. For life* program, requiring the caregivers' home to be a smoke-free zone with signs to indicate this, using written cautions and counselling if the agreement was breached by the caregiver, making unannounced home inspection visits and requiring both spouses to formally agree to the policy.

Discussion

The provision of quality child care is increasingly recognised as an essential family service and has recently achieved a high political profile. The percentage of all Australian children under 12 years of age attending formal child care increased from 12% in 1984 to 18% in 1990.[19] Family Day Care is the choice of many parents, who value the personal and home-like nature of these services. Use of Family Day Care in Australia is likely to grow, particularly in rural areas where smaller populations cannot support long day care centres. In 1990, there was an unmet demand for Family Day Care for some 75 700 children under 12 years of age. Of these children, 70% were aged less than five years and 60% lived in non-metropolitan areas.[19] The health and welfare of children in Family Day Care is a primary concern, not only of parents but of Family Day Care administrators, as evidenced by the excellent response to our survey.

More than 65% of the 88 Family Day Care schemes surveyed had no formal policy about smoking. Most of these merely asked caregivers not to smoke while caring for children. In 86 of these New South Wales Family Day Care schemes (about one-third of all schemes in Australia) an estimated 2045 children are potentially exposed to environmental tobacco smoke. Many of these children are in the vulnerable 0–4 years age range. Seventy-one per cent of children

attending Family Day Care in 1991 were less than five years of age.[18] Many are also potentially exposed for long hours while in care. In 1991, children attended Family Day Care for a mean of 20.5 hours per week.[18]

The responses to our survey raised legal questions regarding the status of the home as a workplace and whether the self-employed are subject to regulations covering smoking in the workplace. The regulation of Family Day Care differs between the eight Australian States and Territories. In New South Wales, licensing is subject to the *Children's (Care and Protection) Act 1987* and two sets of regulations made under it, the Family Day Care Services Regulations and the Home-based Child Care Services Regulations. The providers of these services are also required to comply with a Code of Practice and have general obligations with respect to the health and welfare of the child. In none of these regulations or the Code is smoking specifically mentioned.

The issue of the health consequences of exposure to cigarette smoke has become a prominent legal issue in Australia since *AFCO v. Tobacco Institute of Australia 1991*[20,21] and *Sholem v. New South Wales Health Department 1992*.[22,23] Both cases have given much latitude for future negligence actions based on injuries caused by such exposure. The general principles of negligence established by these cases would most certainly extend to the Family Day Care setting. A duty of care is owed by carers to the children under their care, and a negligent act (anything likely to cause harm to the children) may breach that duty. Injury due to that negligence may justify an action against the person responsible. Public knowledge and awareness about the hazards of environmental tobacco smoke are now sufficiently widespread to suggest that a carer who exposes children to cigarette smoke would be in breach of her or his duty of care. Injury from that exposure can be both chronic or acute. Provided it can be linked to the exposure (i.e., the association is more likely than not), the child may have a successful negligence claim. Such legal actions are highly speculative, and also undesirable because they focus on compensation for injury received rather than on prevention.

Caregivers recognise that they have responsibilities to the children in their care. In New South Wales, the position is made explicit in the Code of Conduct, which imposes a general duty on carers to protect the "health, welfare and progress" of the child.[24] Exposing children to tobacco smoke is inconsistent with that duty. In Victoria, the city of Coburg recently required carers to stop smoking while children are in their care. Although there is no legal power to require this, the Council, as "broker" between consumers and providers, exercises considerable de facto supervisory influence and claims to have implemented the new policy without major difficulty. The Coburg experience provides a model for low key change to policies in other States and local government authorities.

Resistance to the idea of banning smoking in the carer's home appears to centre on the notion that it is intrusive to regulate what people do in their own home. Many restrictions

already exist on the activities of householders that may put others at risk. The fact that property owners or occupiers can be liable for injuries sustained by others on their premises is a well recognised application of the law of negligence. More particularly, where the home becomes the place of work for those whose business is looking after the well-being of children, arguments about the privacy of the home make no sense, as the NSW regulations with their broad duties of care recognise.

The policy adopted by many schemes, which we would endorse, is that of declaring the Family Day Care home a "smoke-free zone" while children are in care. The issues of providing positive role models for children and enhancing the professional image of Family Day Care suggest that a complete ban on smoking in the presence of children, including in the garden and when outside the home on outings, would be even more desirable.

The disadvantage of a no-smoking policy most frequently mentioned by Family Day Care coordinators in our survey was potential loss of caregivers. Despite this, nearly half the Family Day Care coordinators who gave details of their experiences of implementing a no-smoking policy reported no such problems. This suggests that implementation of a no-smoking policy in Family Day Care is possible without curtailing urgently needed child care services.

A no-smoking policy in Family Day Care is clearly difficult to police and enforce, particularly with regard to spouses, other family members and visitors of caregivers. A "top-down" directive from State government level is more likely to be successful than a requirement for each scheme to individually develop and implement a policy, as scheme administrators need to attract adequate numbers of suitable carers and maintain a good relationship with them. A number of the coordinators in our survey indicated that they would find it easier to get caregivers to cooperate with a "top-down" directive. Our survey results also indicate that the issue of other smokers in the household needs to be specifically addressed in any such policy directive.

Enforcement of a no-smoking policy in Family Day Care can only realistically be achieved with the active cooperation of caregivers. Thus it is important to recognise the difficulties individuals may face in controlling or stopping their smoking habits, as well as the social difficulties which may follow the imposition of a "smoke-free" status on the caregiver's home. As any parent would attest, caring for young children is often a stressful experience, and stress management is clearly an important issue.

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An original symposium

About 2400 years ago Agathon, a young Athenian nobleman, invited a dozen of his friends to a banquet in celebration of the first public performance of one of his tragic plays . . . Socrates was late, as usual. Alcibiades stormed in even later, drunk. The symposiasts talked of love, ate, drank wine and eventually slept fitfully. This behaviour was not considered out of order, for this dinner was a symposium, which in Greek means "to drink together" . . . Like those who hastened to Agathon's party, participants at a scientific symposium expect short speeches, rapid interchange of ideas and socializing. For some reason, however, the write-up of Socrates' wine-fuelled encounter session with his cronies is still better reading than the sober reports of many modern symposia.

— Morgan PP. A sober look at scientific symposia. *Can Med Assoc J* 1985; 133: 12.